2017

Montana Child Abuse & Neglect Prevention Evaluation

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Acknowledgment

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Executive Summary

Child maltreatment is an unfortunate reality for many children across the state of Montana. According to the most recent state statistics, 1,868 Montana children were determined, through official investigation to be victims of child abuse or neglect in 2015 (USDHHS, 2017). Many more children are abused and neglected yet never come to the attention of official reporting agencies like Child and Family Services (CFS). The Montana Children's Trust Fund (MT-CTF) works to prevent child abuse and neglect before it ever occurs.

The MT-CTF contracted with Dr. J. Bart Klika at the University of Montana School of Social Work to complete a statewide evaluation organized around the four priority areas of the Center for Disease Control and Preventions (CDC) Essentials for Childhood Framework. The evaluation included compilation of data regarding risk factors for child abuse and neglect (by Child and Family Service region), a scan of the policy and practice landscape for infants and toddlers in Montana using the Zero to Three Toolkit, and a review of social norms research and examples of statewide social norms campaigns.

The following recommendations came from the evaluation:

Recommendation 1: Participate in the maintenance of a statewide prevention resource list.

Recommendation 2: Develop and conduct trainings on the public health approach to prevention.

Recommendation 3: Address cultural needs in child abuse prevention programs.

Recommendation 4: Support initiatives to address family economic indicators.

Recommendation 5: Monitor regional trends in child maltreatment.

Recommendation 6: Convene stakeholder group to finalize Zero to Three Toolkit and develop a plan of action.

Recommendation 7: Develop a plan for understanding and addressing social norms in Montana.

Background & Significance

Child maltreatment is an unfortunate reality for many children across the state of Montana. According to the most recent state statistics, 1,868 Montana children were determined, through official investigation to be victims of child abuse or neglect in 2015 (USDHHS, 2017). Many more children are abused and neglected yet never come to the attention of official reporting agencies like CFS.

The consequences of child abuse and neglect can be severe and long lasting. For example, research shows that children who are maltreated are at increased risk for developing mental health problems, substance use problems, physical health issues, and engaging in antisocial or delinquent activities (Herrenkohl et al., 2013; Klika et al., 2013). The Adverse Childhood Experiences (ACE) Study demonstrates that early adversity is associated with adulthood physical and mental health problems (Felitti et al., 1998). In fact, adverse childhood experiences, such as abuse and neglect, predict some of the leading causes of death in the United States (e.g., heart disease, cancer, diabetes). Treating the consequences of child maltreatment exacts a financial toll. Researchers from the Centers for Disease Control and Prevention estimate that each victim of child abuse and neglect incurs a lifetime cost of nearly $210,000 in treating the consequences of maltreatment (e.g., juvenile justice, special education, child welfare) (Fang et al., 2012). The mounting evidence on the social and financial impacts of child abuse and neglect has been used to argue for increased efforts to prevent child maltreatment before it ever occurs.

Prevention Framework

Those subscribing to a public health approach to child maltreatment prevention discuss the timing at which prevention efforts will occur. Tertiary prevention, one of the most common forms, is initiated after child abuse and neglect already occurred. With tertiary prevention, the goal is to stop future maltreatment from occurring and to work on addressing and minimizing the impacts associated with the maltreatment. Secondary prevention works to identify individuals and families at high risk for abuse or neglect, but who have not yet engaged in abusive or neglectful behavior. This form of prevention is often achieved through screening of children and families for the presence of risk factors for child abuse and neglect. Primary prevention is implemented before abuse and neglect ever occur. Such strategies are often applied universally to populations with the goal of mitigating the risk factors for child abuse and neglect.

Evaluation Plan

The original goal of the Montana Child Abuse and Neglect Prevention Evaluation was to identify/map the current child abuse and neglect prevention initiatives currently in place across the State—with a particular focus on primary and secondary prevention efforts. In addition, the current evaluation project was intended to provide a proposal for future data analysis regarding risk factors and risk populations for child abuse and neglect statewide. Finally, summaries of norms research and policy frameworks were to be provided for consideration in future phases of the evaluation project. The goals and activities of the evaluation were organized around the 4

aims of the Centers for Disease Control and Prevention (CDC) Essentials for Childhood Framework (see Essentials for Childhood).

For reasons explained below, the evaluation changed during the information gathering process. Goal 1 was not achieved as planned yet Goal 2 and Goal 4 provided more information than originally intended (including analysis of the Zero to Three tool and stakeholder survey). Goal 3 was completed as proposed in the initial evaluation plan.

Findings

Goal 1: Mapping Child Abuse and Neglect Prevention

As initially conceived, the current evaluation was intended to map primary and secondary child abuse and neglect prevention programs across the state of Montana. In doing so, the Montana Children's Trust Fund (MT-CTF) would have a refined understanding of statewide prevention services and could, in combination with data demonstrating prevention needs, strategically fund prevention initiatives. The plan for mapping prevention resources was outlined in the approved evaluation plan and consisted of key stakeholder interviews combined with a snowball sampling approach to identify and locate prevention programs. After conducting a series of 5 interviews with key stakeholders (e.g., state directors, CFS employees, social service executive directors), interviewing participants at the Montana Child Abuse and Neglect Conference, and asking for responses on the stakeholder survey[1] it became apparent that this task would be beyond the scope of the current evaluation for 3 reasons. First, interviewees reported that very few programs focus on "upstream" (i.e., primary and secondary prevention) approaches to child abuse and neglect prevention. Instead, most programs focus on working with children and families *after* child abuse or neglect has been identified (i.e., tertiary prevention). Primary/secondary prevention services do not exist in large numbers or across all communities in Montana. Second, participants supplied names of organizations and agencies providing tertiary prevention services, not those focusing on primary and secondary prevention. In many cases, Child and Family Services was identified as the main agency/organization conducting child abuse and neglect prevention work suggesting a potential knowledge gap regarding the meaning or definition of "prevention." Third, the MT-CTF already participates in the maintenance and awareness of a statewide resource list housed under the Department of Justice (DOJ) Child and Family Ombudsman. Duplication of this resource list was deemed unnecessary.

In the process of trying to understand what prevention resources exist statewide, the Board of the MT-CTF was also interested in pulling together data on risk factors associated with child abuse and neglect for the six CFS regions in Montana. Data for this section comes primarily from Kids Count and was compiled by Peter Hanes (AmeriCorps VISTA with the MT-CTF). Child welfare data was provided by Montana Child and Family Services.

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[1] For a list of agencies and organizations from the stakeholder survey, see Appendix A. For more information on statewide resources, please the DOJ at 1-844-25CHILD (4453).

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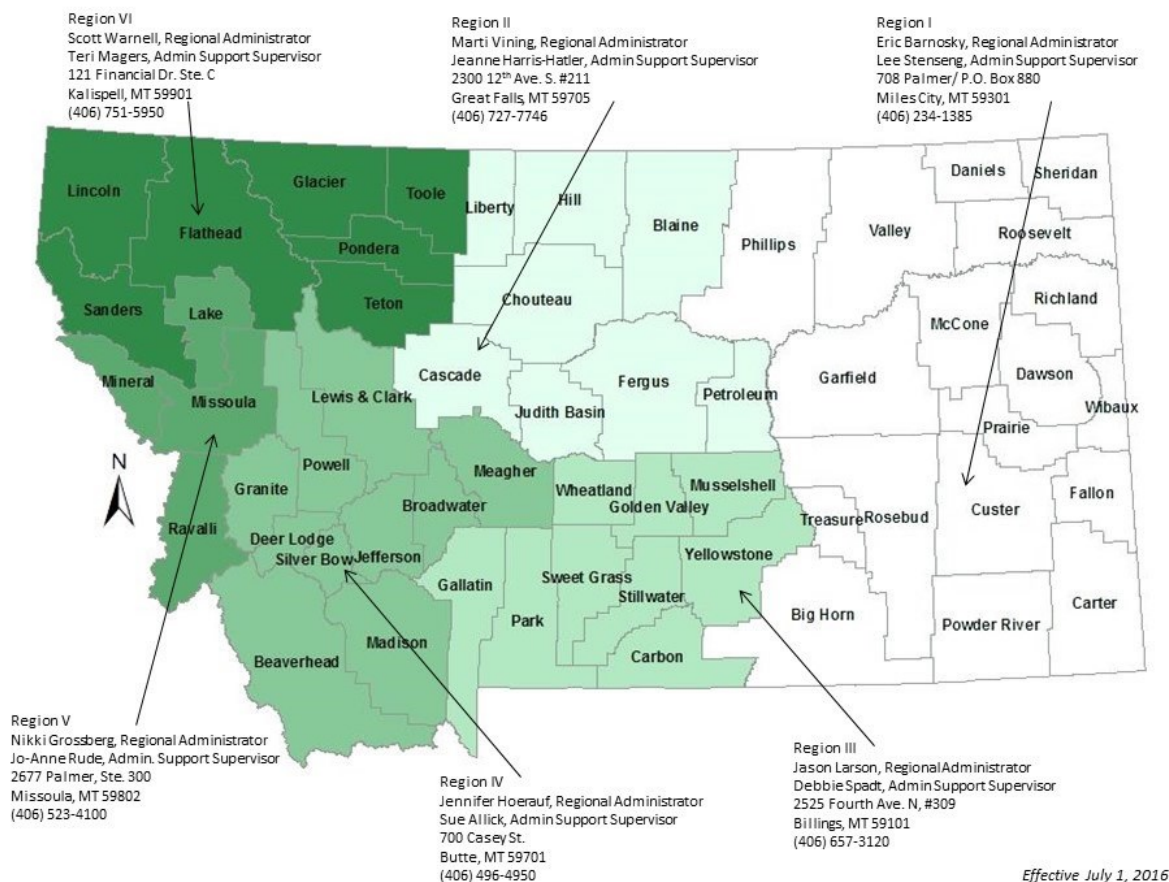(406) 657-3120

Effective July 1, 2016

Table 1 provides a breakdown of the population of children under the age of 20 years by race/ethnicity. County-level breakdowns can be found in Appendix B.

Table 1. Population under 20 by race.

Region	Total Population Under 20	White Population Under 20	AI/AN Population Under 20	Hispanic Population Under 20
Region 1- East	27,042 (100%)	17,157 (63.45%)	8,416 (31.12%)	1,431 (5.30%)
Region 2- North Central	32,808 (100%)	25,254 (77.8%)	4,777 (14.56%)	1,840 (5.61%)
Region 3- South Central	74,033 (100%)	66,017 (89.17%)	3,282 (4.43%)	5,110 (6.9%)
Region 4- Southwestern Region	35,412 (100%)	32,397 (91.49%)	964 (2.72%)	1,858 (5.25%)
Region 5- Western Region	43,605 (100%)	35,827 (82.16%)	3,940 (9.03%)	2,464 (5.65%)

Region	Total Population Under 20	White Population Under 20	AI/AN Population Under 20	Hispanic Population Under 20
Region 6- Northwestern Region	38,299 (100%)	32,026 (83.62%)	4,217 (11.01%)	1,569 (4.1%)
State of Montana	251,199 (100%)	208,678 (83.07%)	25,573 (10.18%)	14,269 (5.68%)

Source. Kids Count.

An overwhelming majority of children in Montana identify as white/Caucasian however, a significant proportion (31%) of children in Region 1 (East) identify as Native American.

Table 2 provides data on economic indicators including unemployment rates, poverty, and median income. County-level breakdowns can be found in Appendix C.

Table 2. Economic indicators by region.

Region	Average Unemployment Rate	Average Poverty Rate	Average Median Income
Region 1- East	3.83%	13.73%	$46,727.94
Region 2- North Central	4.38%	17.83%	$40,293.25
Region 3- South Central	4.20%	13.72%	$45,834.89
Region 4- Southwestern Region	4.81%	14.55%	$45,098.30
Region 5- Western Region	6.38%	16.98%	$40,572.00
Region 6- Northwestern Region	7.09%	18.66%	$40,147.86
State of Montana	4.70%	14.6%	$44,111.95

Source. Kids Count.

Region 6 (Northwestern Region) reported the highest unemployment rate, highest poverty rate, and lowest average median income compared to all other Montana regions. While Region 6 demonstrates the highest need, other regions (e.g., Region 2, North Central) show comparable levels across some of the economic indicators.

Table 3 provides data on insurance coverage including enrollment in Healthy Montana Kids by region. County-level breakdowns can be found in Appendix D.

Table 3. Insurance coverage by region.

Region	Insurance Coverage	Healthy Montana Kids Enrollment
Region 1- East	76.93%	12,406 (50.00%)
Region 2- North Central	79.08%	14,439 (48.44%)
Region 3- South Central	81.72%	27,185 (41.24%)
Region 4- Southwestern Region	81.83%	14,466 (46.11%)
Region 5- Western Region	77.39%	20,501 (53.98%)
Region 6- Northwestern Region	76.14%	20,873 (59.41%)
State of Montana	79.30%	110,007 (48.89%)

Source. Kids Count.

Region 6 (Northwestern region) has the lowest rate of insurance coverage and the highest rate of enrollment in Healthy Montana Kids.

Table 4 provides data on Supplemental Nutrition Assistance Program (SNAP) participation by region. County-level breakdowns can be found in Appendix E.

Table 4. Supplemental Nutrition Assistance Program (SNAP) participation by region.

Region	SNAP Participants of All Ages	Participants as a Percentage of Total Population
Region 1- East	12,558	13.02%
Region 2- North Central	16,243	14.62%
Region 3- South Central	24,350	8.12%
Region 4- Southwestern Region	16,387	10.5%
Region 5- Western Region	24,705	13.21%
Region 6- Northwestern Region	23,293	14.88%
State of Montana	118,704	11.60%

Source. Kids Count.

Region 6 (Northwestern region) reports the highest rate of SNAP participation with Region 2 (North Central region) reporting comparable rates.

Appendix F provides data on child welfare caseloads and rates of substantiation (by region) for the first quarter of 2017. This data may help the MT-CTF understand the regions of highest need in regards to child abuse and neglect. Region 3 (South Central region) has the highest number of children in care[2] and accounts for nearly 25% of the statewide allegations for abuse and neglect. For physical abuse and neglect, Region 3 reported the highest raw number of allegations;

[2] Caution should be exercised when examining raw numbers. Intuitively, regions with larger populations of children under 18 years will likely report higher raw numbers of abuse and neglect caseloads and allegations. Expressing caseloads and allegations as a percentage of the total population of children under the age of 18 may allow for comparison across regions.

however, when looking at the percentage of allegations that result in substantiation for physical abuse and neglect[3], Region 1 (Eastern region) had the highest substantiation rate for physical abuse at 25% and Region 2 (North Central region) had the highest substantiation rate for neglect at 27%. For child sexual abuse, Region 5 (Western region) had the highest raw number of allegations yet Region 1 (Eastern region) had the highest substantiation rate at 70%.

Although these data represent "after-the-fact" cases of child abuse and neglect, they do give some indication as to where concentrations of maltreatment are occurring in Montana. Moving forward, the MT-CTF is encouraged to utilize CFS trend data (by region) to better inform child maltreatment prevention efforts. The MT-CTF may also seek to collect or locate additional data on risk factors associated with child abuse and neglect, for example, mental health and substance abuse measures.

Goal 2 & Goal 4: Data Analysis and Policy Landscape
The national organization, Zero to Three (see Zero to Three) has a mission to provide infants and toddlers with strong starts in life by ensuring that communities have the appropriate knowledge to create the conditions and contexts for healthy child development. Zero to Three supports the professional development of direct service workers through products (e.g., Toolkits), trainings, and national conferences. In addition, Zero to Three assists states in the development and implementation of family-friendly policy through the use of the "Zero to Three Self-Assessment Toolkit" (see Zero to Three Toolkit). The Toolkit is a user-friendly template which helps states assess data across 4 domains: health, strong families, learning experiences, and system building/collaboration. The goal of the Toolkit is to help states better understand needs and gaps and to set priorities for future policy. Further, the Toolkit allows states to compare statewide data to national trends across the 4 assessed domains.

The recommended process for completing the Toolkit is to use the data provided by Zero to Three to fill-in the various sections of the Toolkit (see Toolkit for descriptions of the data sources). Then, it is recommended to engage a diverse group of statewide stakeholders to review the Toolkit findings, add any missing data, make any corrections/updates to the data, and refine the data in the Toolkit as necessary. This process is iterative and continues as new data becomes available. For the current evaluation, Peter Hanes (AmeriCorps VISTA with the MT-CTF) assisted in the completion of the Toolkit. To the best of our ability, data were provided on all sections of the Toolkit yet some sections remain blank due to lack of accessible data. Due to time constraints, the evaluation team was unable to gather a group of key stakeholders to review the findings of the Toolkit to check for accuracy, add missing data, and develop a policy plan of action. Therefore, caution should be exercised from drawing firm conclusions from the Toolkit findings until a group of key stakeholders provides input. For more information on previous statewide needs assessments related to children, families, and early intervention, please visit DPHHS Home Visiting Needs Assessment.

The Zero to Three Toolkit also provides survey questions for key stakeholders. Key Montana

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[3] Number of substantiated cases divided by the number of allegations.

stakeholders were invited to participate at the Title 1 Conference in Helena and at the Child Abuse and Neglect Conference in Helena. In addition, the evaluation team sent an anonymous link to the survey to the Best Beginnings Councils across Montana. In total, 111 stakeholders completed the survey but only 75 participants completed the full survey. Those with incomplete information were dropped from the final analysis. These stakeholders represented the following sectors: education (e.g., teacher, superintendent, special education, school counseling, Head start), state government, social work, mental/behavioral health, and medical (e.g., RN, dietician, Pediatrician). The following counties in Montana were represented in the stakeholder survey: Big Horn, Cascade, Carbon, Carter, Fergus, Flathead, Gallatin, Hill, Lewis & Clark, Madison, Mineral, Missoula, Park, Phillips, Pondera, Ravalli, Tool, Valley, and Yellowstone. As noted in the tables, there is a significant amount of missing data across the survey items. While responses to the questions are helpful, caution should be exercised when drawing conclusions from the stakeholder survey.

Good Health
This section explores Montana data regarding physical health, social-emotional health, and access to developmental screenings.

1. *How are infants, toddlers, and their families doing in Montana?*

Approximately three-quarters of Montana mothers receive prenatal care which is slightly higher than the national average (71%). Thirty-five percent of births are covered by Medicaid compared to 45% nationally. Infant mortality in Montana is at approximately 5.6 deaths per 1,000 births while the national average is around 6.4 per 1,000. At two years of age, only 67% of infants/toddlers are up-to-date on immunizations compared to 73% nationally. Montana has a slightly elevated rate (9%) of children under the age of 6 years with no health insurance compared to the national average (6%). Approximately 95% of Montana infants on Medicaid receive at least one Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam (90% nationally) however only 22% of children under the age of 6 have received a developmental screening (30% nationally).

2. *Does Montana have policies in place to support good health?*

Physical health. Income eligibility for Medicaid/CHIP (Children's Health Insurance Program) is set at 162% of the federal poverty level for pregnant women, making fewer women eligible for these programs than if the level were set at 200% of the federal poverty level (a customary practice in other states). For children birth to 5 years, eligibility is set at 266% of the federal poverty level. Both pregnant women and children in Montana receive temporary coverage until Medicaid/CHIP eligibility can be fully determined. Montana does not require newborn screenings for Recommended Uniform Screening Panel (metabolic, endocrine, hemoglobin, and other disorders). The American Academy of Pediatrics (AAP) provides recommendations for an EPSDT periodicity schedule for preventive pediatric health care for children under 1 year, children 1 year to 2 years, and children 3 years to 5 years. Montana only requires 6 screenings for children under 1 year despite the AAP recommendation for 7 screenings yet meets the AAP recommendations for children 1 year to 2 years and for those 3 years to 5 years.

Developmental screenings. Montana requires that children on Medicaid receive developmental screenings and that Medicaid reimbursement is provided for the use of a standardized developmental screening tool.

Social-emotional health. Montana has mechanisms in place to ensure clinicians can diagnose infant-toddler mental health conditions. However, Medicaid in Montana does not require that a pediatric primary care clinician use a standardized screening tool to assess social-emotional or behavior issues although developmental and behavioral screenings are recommended at 9 months, 18 months, 2 ½ years, and 4-5 years of age. Maternal depression screenings at prenatal visits are reimbursed by Medicaid as long as providers use an evidence-based screening tool.

3. *Does Montana allocate state or federal funds to services that promote good health?*
Physical health. Montana does not allocate funds to support health care consultation for early care and education providers. Funds are allocated for health and safety initiatives including oral health, safe sleep, and shaken-baby syndrome however are not provided for obesity prevention, environmental hazards (e.g., lead poisoning), or car seat safety.

Social-emotional health. Montana does not allocate funds to support mental health consultation for early care and education providers or other child serving professionals, screening for maternal depression, or the co-location of mental health clinicians in pediatric primary care settings.

Developmental screening. Montana does not fund initiatives to expand access to development screening or referrals to needed services.

4. *How are current policies and programs meeting the needs of infants, toddlers, and their families in Montana? (responses from Stakeholder Survey)*

Table 5. Policies and programs for physical health.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
PHYSICAL HEALTH						
Pregnant women have access to and regularly receive prenatal care throughout pregnancy, as well as postpartum care.	1%	23%	57%	13%	6%	Post-partum care is not prioritized
Infants and toddlers regularly receive recommended well-child visits.	0%	37%	47%	4%	12%	
Infants and toddlers have an identified medical home.	0%	43%	31%	1%	25%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Primary care providers are reimbursed adequately for the time to provide child development guidance in well-child visits.	13%	25%	13%	11%	35% don't know 3% missing	
Eligible women and children utilize the Women, Infants, and Children (WIC) program.	0%	52%	32%	5%	11%	Under-utilized
Eligible families with infants and toddlers utilize the Supplemental Nutrition Assistance Program (SNAP).	1%	41%	35%	4%	19%	
Infant-toddler caregivers and programs access health care consultation as needed.	4%	37%	23%	3%	33%	
Young children live in healthy environments, free from environmental hazards.	3%	65%	29%	0%	3%	Many children who are experiencing homelessness
Families with young children have opportunities to access nutritious food.	0%	52%	43%	3%	2%	Opportunities exist but limited access (e.g., transportation)

N=75

Table 6. Policies and programs for developmental screenings.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
DEVELOPMENTAL SCREENING						

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Families with infants and toddlers access developmental screening in pediatric and/or early care and education settings.	0%	65%	21%	4%	10%	
When developmental screening indicates a need for services, families with infants and toddlers are referred to and have access to appropriate services.	0%	43%	37%	11%	9%	Depends on community resources
Screening results are regularly shared (with parent consent) with the providers making referrals, so that they can continue to support and monitor children's needs.	1%	39%	31%	9%	20%	
Primary care providers are adequately reimbursed for use of standardized developmental screening tools.	8%	17%	12%	8%	55%	

N=75

Table 7. Policies and programs for social-emotional health.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
SOCIAL-EMOTIONAL HEALTH						
Pregnant and postpartum women have access to and receive maternal depression screenings and mental health services, as needed.	8%	57%	5%	3%	27%	No consistency in screening for postpartum depression (PPD)

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Parents access resources on how to support the social-emotional development of their infants and toddlers.	8%	72%	5%	3%	12%	
Infant-toddler professionals receive training on how to address the mental health needs of infants and toddlers.	9%	55%	11%	7%	18%	Left up to individual agencies
Infant-toddler caregivers and programs access mental health consultation services, as needed.	9%	59%	8%	0%	24%	
Infants and toddlers with social-emotional or behavioral issues are assessed, diagnosed, and treated by trained professionals.	5%	71%	7%	4%	13%	Shortage of providers
Families with infants and toddlers access mental health services in pediatric primary care settings.	12%	59%	5%	1%	23%	
Primary care providers are adequately reimbursed for use of standardized early childhood mental health screening tools.	9%	29%	3%	4%	55%	July 1, 2017, pediatricians will be able to bill Medicaid for maternal mental health screenings

N=75

Strong Families

In this section, data is used to explore how well the basic needs of Montana families are being met, the support given to high quality parent education and home visiting programs in Montana,

how well needs of children in the child welfare system in Montana are being met, and progress towards promoting paid family leave in the state.

1. *How are infants, toddlers, and their families doing in Montana?*

In general, Montana is similar to national percentages for the following: percentage of maltreated children who are less than three years of age (MT=27%; US=27%), percentage of children less than three years old who are experiencing residential mobility (MT=24%; US=23%), percentage of children less than 6 years old with no parent in the labor force (MT=8%; US=10%), percent of children from birth to 5 years old with family employment affected by child care issues (MT=15%; US=14%), percent of Temporary Assistance for Needy Families (TANF) program families with at least one child less than 3 years old (MT=36%; US=37%), percent of Supplemental Nutrition Assistance Program (SNAP) recipients who are less than 5 years old (MT=14%; US=14%), and the percent of households receiving Low Income Home Energy Assistance Program (LIHEAP) heating assistance with a child less than 6 years old (MT= 22%; US=22%). Thirty-five percent of children entering the foster care system are less than 3 years old compared to 31% nationally. Approximately 14% of Montana children experience three or more risk factors compared to 18% nationally and only .08% of children from birth to 18 years old live in census tracts with poverty levels of 40% or higher compared to 4% nationally.

2. *Does Montana have policies in place to support strong families?*

Basic needs. In Montana, single parents receiving Temporary Assistance for Needy Families (TANF) are not exempt from work requirement until the youngest child is at least 1 year old. In addition, work requirements for single parents on TANF with children less than 6 years old equate to 27 hours per week, not the standard 20 hours. Finally, exemptions/extensions are not offered for the TANF benefit time limit for women who are pregnant or caring for a child less than 6 years old. The state minimum wage of $8.15/hour exceeds[4] the federal minimum wage of $7.25/hour. Montana does not exempt single-parent families with children less than 3 years old below the poverty level from personal income tax, nor does Montana offer refundable state earned income tax credit or dependent care tax credit.

Home visiting/Parent education. Montana provides families with referral options for one of four evidence-based home visiting models through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program: Family Spirit, Nurse-Family Partnership, Parents as Teachers, and SafeCare Augmented (see DPHHS Home Visiting). In addition, Montana has core competencies for parent education/home visiting professionals.

Child welfare. When safe and appropriate, visitation between birth parents and infants and toddlers in out-of-home care occur at least 2 times per week (more frequently if possible). Compared to older children, infants and toddlers in out-of-home care in Montana do not receive more frequent case reviews or more frequent permanency hearings. While no state policy exists to promote keeping infants and toddlers in their first placement in out-of-home care, every effort is made to minimize the number of moves a child needs to make. After an infant or toddler enters out-of-home care, concurrent planning begins and continues until permanency is achieved.

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[4] For businesses with gross annual sales of $110,000 or less, minimum wage is $4.00/hour.

Family leave. Montana has yet to adopt a paid family leave policy providing full or partial replacement of wages after birth or adoption. Further, no statewide policy requires employers to provide paid sick leave that allows parents to take paid time off when a child is sick.

3. *Does Montana allocate state or federal funds to services that promote strong families?*
Basic needs. Montana supplements federal resources for nutrition programs that reduce food insecurity for young children. In addition, Montana allocates funding for initiatives to address affordable housing, domestic violence, substance abuse, homelessness, and job training.

Home visiting/Parent education. Montana allocates funds to support evidence-based home visiting services for expectant parents and families of young children, in addition to evidence-based or research-informed parent education programs in early childhood centers, pediatric primary care, or other settings. Furthermore, Montana disseminates parenting information to a wide range of parents through various platforms (e.g., social media, print material).

4. *How are current policies and programs meeting the needs of infants, toddlers, and their families in Montana? (responses from Stakeholder Survey)*

Table 8. Policies and programs for strong families.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Families can find the services they need for their infants and toddlers through cross-program referrals and information and referral agencies.	3%	51%	16%	7%	23%	
Families receive information and services responsive to their home culture and language.	3%	43%	21%	4%	29%	Very limited cultural services
State policies support a coordinated multigenerational approach to addressing the needs of at-risk children and their families.	16%	39%	7%	3%	35%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Families with infants and toddlers who face multiple risk factors (e.g., very low income, homelessness, and family violence) can access programs and services that work together to support them.	1%	52%	15%	5%	27%	

N=75

Table 9. Policies and programs to meet family basic needs.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
BASIC NEEDS						
Families can access needed education, skill training, job opportunities, and work supports to move into stable work that generates a livable wage.	9%	56%	7%	3%	25%	
Adequate housing options are available to low-income families.	17%	51%	4%	4%	24%	Long waitlists
Adequate energy assistance options are available to low-income families.	4%	52%	16%	4%	24%	

N=75

Table 10. Policies and programs for home visiting and parent education.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
HOME VISITING/PARENT EDUCATION						

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Expectant parents and families with infants and toddlers can access evidence-based home visiting programs.	4%	48%	13%	9%	26%	
Families with infants and toddlers can access evidence-based parent education programs, as needed.	1%	49%	16%	8%	26%	
Home visiting supports extend to families, friends, and neighbors caring for children with working parents.	8%	36%	11%	7%	38%	
Families who wish to increase their leadership and advocacy skills can access leadership initiatives.	13%	37%	4%	5%	41%	
Parenting resources are readily available to all parents of young children seeking information on how to support healthy child development.	4%	39%	19%	11%	27%	

N=75

Table 11. Policies and programs for child welfare.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
CHILD WELFARE						
Infants and toddlers in out-of-home placements have frequent contact with birth parents, when safe and appropriate.	4%	32%	8%	5%	51%	Need more visits

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Child welfare workers and judges receive ongoing training about child development and the effect of trauma and use that knowledge to guide their work with infants and toddlers in the child welfare system.	4%	24%	11%	4%	57%	
Families (including birth families, permanent guardians, and adoptive families) have access to continued post-permanency supports, such as adoption subsidies and therapeutic services, after permanency has been achieved.	3%	24%	5%	0%	68%	Bio-families have the least access
Families who are investigated for maltreatment, but whose cases do not receive substantiation, are connected to support services.	7%	27%	11%	3%	52%	Does not happen enough
Children in the child welfare system receive screenings and services to promote their learning and development, such as early intervention and high-quality early care and education.	4%	32%	12%	12%	40%	

N=75

Table 12. Policies and programs for family leave.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
FAMILY LEAVE						
Working families can access paid family leave after birth or adoption.	16%	44%	3%	5%	32%	Very few can access
Working families can access paid sick leave when a young child is sick.	1%	65%	5%	3%	26%	
Working parents in the state receive work-life benefits that allow them to balance work with caring for young children.	16%	47%	3%	3%	31%	Rarely

N=75

Positive Learning Experiences
In this section, data is used to explore quality of child care in Montana, Early Head Start (EHS), and early interventions to promote learning and development.

1. *How are infants, toddlers, and their families doing in Montana?*
Fifty-seven percent of Montana parents read to their children (under 5 years old) everyday while the national estimate is approximately 48%. The cost of infant care in child care centers as a percentage of total income for single mothers in Montana is high, at approximately 42% (37% nationally). For information regarding childcare in Montana, please see DPHHS Childcare.

Montana children report higher percentages of federal childcare support (MT=31%; US=27%) and eligible infants and toddlers receiving EHS (MT= 14.27%; US=4.5%) than national estimates. The number of children (4 months to 5 years old) who are at moderate to high risk for developmental or behavioral problems is around 25%, close to the national average of 26%. Approximately 2% of infants and toddlers in Montana (3% nationally) receive Part C early intervention services.

2. *Does Montana have policies in place to support positive early learning experiences?*
Early intervention. Montana does not include at-risk children in the definition of eligibility for Individuals with Disabilities Education Act (IDEA) Part C Early Intervention program.

Child care. Family eligibility for child care subsidies is not at or above 200% of the federal policy level in Montana. The reimbursement rate for state child care in Montana is not at or above the recommended 75th percentile of the market rate. However, Montana does provide higher subsidy reimbursement rates to programs providing infant-toddler care than to programs serving older children and limits child care subsidy co-payments to 7.2% of family income for families at 100% of the federal poverty level. In Montana, the ratio requirements for infant and toddlers in licensed center-based and family child care settings is 4:1 for children up to 2 years

old and 8:1 for children between 2 years and 3 years of age, slightly higher than national standards. A statewide early care and education Quality Rating and Improvement System (QRIS) has been implemented in Montana including quality indicators for programs serving infants and toddlers. Montana requires that there is a primary caregiver for every infant and toddler in child care centers. No policy in Montana requires that child care centers offer activities that actively encourage and support infants' and toddlers' exploration of the environment. Montana does encourage center-based programs to offer opportunities for interaction with parents, has early learning guidelines for infants and toddlers, developed/adopted core knowledge and competencies for early care and education providers, developed/adopted an infant-toddler professional credential with 60-hours of professional development, and has a workforce registry to track the qualifications and professional development of the early care and education workforce.

3. *Does Montana allocate state or federal funds to services that promote positive early learning experiences?*

Montana does support initiatives for high-quality early care and education programs for infants and toddlers and initiatives to promote early language and literacy, including providing books to low-income families.

Early Head Start (EHS). Montana does not allocate funding to supplement EHS in order to increase the number of families served by EHS, extend the day, or improve the quality of services.

Child care. Montana allocates funding for a network of infant-toddler specialists that provide on-site technical assistance to child care providers, grants/incentives/resources to programs to promote high-quality care and early learning for infants and toddlers, scholarships/other supports to help infant-toddler professionals gain additional skills, and support for quality improvements in family child care programs. On the other hand, Montana does not fund wage enhancements or other supports to help infant-toddler professionals increase compensation/benefits or to create grants/loans to early childhood programs to renovate or construct facilities to serve infants and toddlers.

4. *How are current policies and programs meeting the needs of infants, toddlers, and their families in Montana? (responses from Stakeholder Survey)*

Table 13. Policies and programs for early intervention.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
EARLY INTERVENTION						

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Infants and toddlers with potential developmental disabilities or delays are referred to and receive Part C Early Intervention services, when eligible.	0%	37%	15%	8%	40%	
Infants and toddlers exiting early intervention have either completed the Individualized Family Service Plan or transitioned to appropriate services to support their development.	0%	19%	15%	8%	58%	
Infants and toddlers who have a substantiated case of child abuse or neglect are referred to Part C Early Intervention for evaluation.	1%	20%	7%	9%	63%	
Infants and toddlers in the child welfare system who have developmental delays but do not meet Part C eligibility receive needed services.	3%	28%	9%	1%	59%	

N=75

Table 14. Policies and programs for child care.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
CHILD CARE						
Families in need of child care for their infants and toddlers can access affordable, high-quality care in their communities.	9%	48%	7%	5%	31%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Families can access a network of child care resource and referral agencies to help identify their needs and refer to appropriate child care programs.	1%	37%	23%	7%	32%	
Infant-toddler child care programs are culturally responsive and address the needs of young children learning English as a second language.	12%	25%	3%	0%	60%	
Infants and toddlers with disabilities can access supports needed to participate in child care programs.	13%	32%	9%	7%	39%	
Infant-toddler child care providers regularly use family engagement strategies to support parents as their child's first teachers.	8%	41%	5%	5%	41%	
Infant-toddler specific professional development is available to child care professionals through the following: Higher education	1%	35%	4%	13%	47%	
Infant-toddler specific professional development is available to child care professionals through the following: In-service training	1%	35%	5%	13%	46%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
Infant-toddler specific professional development is available to child care professionals through the following: Technical assistance	0%	31%	4%	7%	58%	
Infant-toddler child care professionals are paid at wages comparable to those of other early care and education professionals.	33%	16%	4%	1%	46%	
State technical assistance providers, coaches, licensing specialists, and other individuals providing support to child care providers are trained in infant-toddler development.	1%	25%	8%	8%	58%	
Early care and education programs regularly work with community partners such as libraries, museums, parks and recreation, the faith community, etc.	3%	43%	9%	4%	41%	
Family, friend, and neighborhood caregivers have access to supports such as training, consultation, lending libraries, etc.	12%	39%	4%	4%	41%	

N=75

Collaboration & System Building

1. *To what extent does Montana promote collaboration and system building to meet the needs of infants, toddlers, and their families? (responses from Stakeholder Survey)*

Table 15. Policies and programs to promote collaboration.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
PROMOTE COLLABORATION						
Transition policies ensure continuity of services between various infant-toddler program settings, as well as programs for older children.	1%	20%	11%	5%	63%	
Mechanisms exist to coordinate among infant-toddler programs and to link them with other services such as health, mental health, education, child welfare, family support, etc.	5%	33%	7%	5%	50%	

N=75

Table 16. Policies and programs to recruit and engage stakeholders.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
RECRUIT AND ENGAGE STAKEHOLDERS						
Early childhood system development efforts involve diverse representation from stakeholders, from both public and private sectors, who are interested in infants and toddlers.	7%	25%	9%	4%	55%	
Public awareness efforts build public and political will around the needs of infants and toddlers.	8%	35%	9%	7%	41%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
There are champions for investing in high-quality infant-toddler programs who can reach a range of constituent bases.	5%	25%	5%	3%	62%	
Influential state policymakers are supportive of early childhood system building efforts.	8%	35%	5%	3%	49%	

N=75

Table 17. Policies and programs to define and coordinate leadership.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
DEFINE AND COORDINATE LEADERSHIP						
A state-level governance entity oversees and coordinates early childhood services and programs.	3%	16%	7%	21%	53%	
The State Advisory Council on Early Childhood Education and Care includes a focus on the needs of infants and toddlers.	1%	9%	4%	19%	67%	
The state has established leaders inside and/or outside of government promoting improvement in policies for infants and toddlers.	5%	19%	5%	15%	56%	
The state supports connections between state and local system-building efforts.	5%	12%	4%	12%	67%	

N=75

Table 18. Policies and programs to ensure accountability.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
ENSURE ACCOUNTABILITY						
The state has a shared systemic vision for supporting young children and their families.	9%	17%	8%	8%	58%	
Early childhood system-building efforts are informed by research and data on infants, toddlers, and their families.	0%	19%	9%	15%	57%	
The state has an integrated, comprehensive early childhood plan that includes a focus on infants and toddlers, and the plan is reviewed and updated regularly.	8%	5%	1%	15%	71%	
The state has identified desired outcomes for infants and toddlers and monitors key indicators associated with these outcomes.	3%	9%	5%	20%	63%	
The state has a coordinated early childhood data system that houses data on various programs serving infants and toddlers and is used to promote quality improvement.	4%	9%	3%	13%	71%	

N=75

Table 19. Policies and programs to enhance and align standards.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
ENHANCE AND ALIGN STANDARDS						
The state has performed a cross-walk to compare various sets of infant-toddler program standards to ensure that they are aligned and supported by research.	3%	5%	5%	8%	77%	
Various quality improvement strategies for infant-toddler programs (e.g., early learning guidelines, quality rating and improvement system [QRIS], professional development) are aligned rather than parallel efforts.	5%	12%	7%	8%	68%	

N=75

Table 20. Policies and programs to create and support improvement.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
CREATE AND SUPPORT IMPROVEMENT						
The state has clearly defined career pathways for the infant-toddler workforce that are inclusive of a variety of roles for infant-toddler professionals.	7%	11%	7%	9%	66%	
The state has a professional development system that supports the infant-toddler workforce across all service sectors.	8%	15%	4%	8%	65%	

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
The state supports the use of reflective practice to support infant-toddler professionals in improving their practice.	5%	9%	3%	13%	70%	
The state supports quality improvement initiatives in various infant-toddler programs and settings.	3%	8%	11%	11%	67%	
The state supports research and evaluation efforts aimed at continuous improvement of services for infants, toddlers, and their families.	3%	11%	7%	12%	67%	

N=75

Table 21. Policies and programs for strategic financing.

Policies & Programs	No/None	Some	Most	Yes/All	Missing	Summary of Comments
FINANCE STRATEGICALLY						
Available funding sources are used strategically to promote system-building capacity.	4%	20%	5%	3%	68%	
The state addresses the needs of infants and toddlers when investing in Pre-K initiatives.	15%	15%	5%	7%	58%	
Services for infants, toddlers, and their families have adequate and stable funding.	33%	16%	5%	1%	45%	

N=75

Goal 3: Social Norms

For decades, researchers have examined why people believe and act as they do. Many argue that "social norms" are a key driver of our collective thinking and behavior. Social norms refer to the attitudes, values, expectations, and behaviors of a group of people (see Positive Community Norms). Those who study social norms often talk about the relationship between descriptive norms, injunctive norms, and perceptions of norms. Descriptive norms refer to how people actually behave and act. Injunctive norms refer to attitudes, beliefs, expectations, and opinions. One of the most common strategies for assessing descriptive and injunctive norms is to conduct surveys that ask people to report directly on what they think, believe, and do. Early work by Daro and Gelles (1992) assessed descriptive and injunctive norms related to child maltreatment and child rearing more broadly over a 5-year period (1987-1992) by asking participants to self-report opinions, beliefs, and values. The researchers found that although self-reported use of corporal punishment (CP) declined over the 5-year survey period, the rate of CP remained high at 53%.

In a later survey conducted through a partnership between the national organization Prevent Child Abuse America (PCAA) and the Frameworks Institute, descriptive and injunctive norms were assessed in relation to child development, parenting, and child maltreatment (see Frameworks Institute). Again, this survey asked adults to report on their actual thoughts and behaviors regarding the aforementioned topics. The survey found that nearly 53% of adults believed that CP should be used at least "sometimes" as a form of discipline.

The work by Daro and Gelles and the later survey by PCAA and Frameworks are important for at least two reasons. First, these surveys highlight a historical trend in how researchers seek to understand descriptive and injunctive norms (by asking people what they think, believe, and do). Second, these surveys allow us to track trends in issues related to child abuse and neglect (in this example, corporal punishment) over time and to learn whether our interventions are changing the way that people think, feel, and behave.

Norms research, however, shows that how we think, believe, and act (our descriptive and injunctive norms) is often influenced by our perceptions of the thoughts, beliefs, and actions of others in our peer or referent groups. These perceived norms are influential when it comes to our perceptions of people's actions (descriptive norms) and also of their attitudes (injunctive norms). However, research has shown that our perceptions of the thoughts and behaviors of others is often wrong (Linkenbach & Otto, 2014). There is often a gap between descriptive/injunctive norms (also called "actual norms" because they describe how people actually act and feel) and perceived norms whereby we over estimate risky behavior (e.g., how many drinks other adults have in a typical week) and under estimate healthy protective behavior (e.g., how many times per week other adults exercise). Inaccurate perceptions can lead us to engage in unhealthy or risky behavior. For example, if I perceive that most adults use CP as a form of discipline I am more likely to use CP to bring my parenting in-line with the "norm," even if I have a personal belief against its use. The goal of norms research is to understand actual and perceived norms and to identify any gaps or inconsistencies between them. Only recently have researchers started tracking actual and perceived norms related to child maltreatment. The following data is

summarized from a recent report entitled, *Balancing Adverse Childhood Experiences With Hope: New Insights Into the Role of Positive Experience on Child and Family Development* (see Healthy Outcomes from Positive Experiences).

In 2014 and 2015, the national organization Prevent Child Abuse America (PCAA) partnered with The Montana Institute (TMI) to conduct two separate national telephone surveys assessing social norms as they relate to child abuse and neglect prevention. In total, these two telephone-based surveys reached 1,500 residents across the United States. The two surveys did not ask identical questions but assessed similar concepts related to actual and perceived norms:

    a. Attitudes and perceptions of the seriousness of child abuse and neglect
    b. Attitudes and perceptions on whether child abuse and neglect is preventable
    c. Attitudes and perceptions on whether respondents would or should take action if child abuse or neglect was suspected

Results showed a fair amount of agreement between actual and perceived norms regarding attitudes held about the seriousness of child abuse and neglect (i.e., people think that child abuse is a problem and perceive that other adults think it is a problem), whether child abuse and neglect was preventable (i.e., people think that child abuse is preventable and perceive that other adults think that child abuse is preventable), and whether action should be taken if child abuse or neglect is suspected (i.e., people think that they should take action if child abuse or neglect is suspected and think that other adults believe that action should be taken if child abuse or neglect is suspected). Put another way, people were accurately perceiving the norms. On the other hand, a majority of adults (57%) who had ever suspected abuse or neglect took some sort of action yet only a small percentage of adults (3%) accurately perceived these protective actions of other adults. If adults perceive that their behaviors may violate a social norm of acceptance (e.g., intervene in a suspected case of child maltreatment), they may be less likely to engage in that behavior.

In a separate survey conducted by yougov.com (in collaboration with the Centers for Disease Control and Prevention), approximately 2,500 adults across the United States were surveyed by telephone about their attitudes and perceptions associated with parenting young children. In general, parents with children under the age of 5 years report a number of positive parenting practices with their children (e.g., responding to crying, catching child being good, reading to child). However, parents perceive that other adults in their state are not engaging in as many positive parenting practices. Here, we see that there is a gap between actual and perceived norms.

Science of the Positive and the Positive Community Norms Frameworks
Dr. Jeff Linkenbach of The Montana Institute is a leading national expert on the topic of social norms and consults frequently with the CDC and other national organizations on issues related to social norms and child maltreatment (see The Montana Institute). In this section, the Science of the Positive (SOTP) and Positive Community Norms (PCN) Frameworks are briefly described and applied to case examples from Wisconsin and West Virginia.

The Science of the Positive is the scientific study of the ways in which positive factors influence individuals, cultures, and the experiences of those embedded within those cultures (Linkenbach,

2017). One of the underlying assumptions of the SOTP is that positive factors exist within each culture and community, and that there is value in further cultivating these positive factors. Most modern-day research and health communication programs have a problem or deficit focus where the goal is to define, identify, and remediate a problem (Linkenbach, 2001). The SOTP acknowledges that problems exist but places greater emphasis on defining, identifying, and cultivating positive factors. In other words, the SOTP balances concern with hope (Linkenbach, 2016). There are four essential domains to the SOTP process: Spirit, Science, Action, Return.
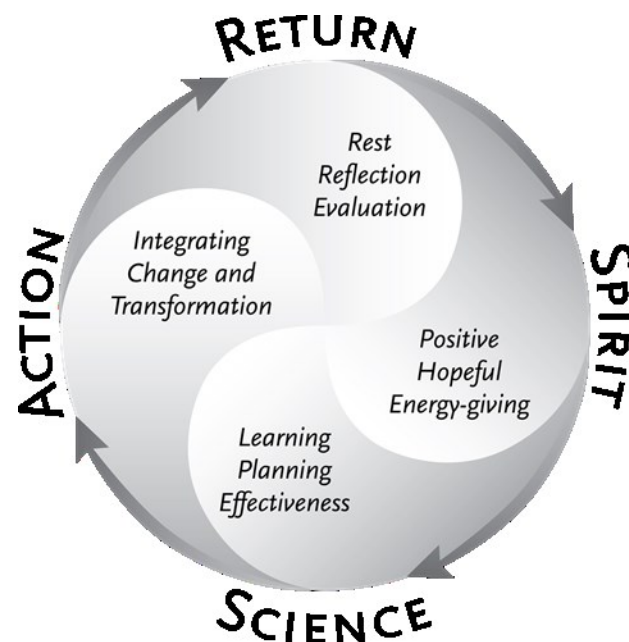
Spirit serves as the foundation of all of the process. Determining the essence or "why" of the work is a necessary first step. Next, the best available *Science* is identified and applied to guide *Action*, or the "doing" of our work. Although this process can take years to implement, it is important to have a period of reflection following Action. During this *Return* part of the process, communities have the opportunity to reflect upon their successes, gain clarity of purpose, and redefine their Spirit for moving forward.

The Positive Community Norms Framework seeks to transform cultures by using the core principles of the SOTP to cultivate positive community norms (Linkenbach, 2017). As seen in the PCN logic model, the goal of increasing positive community norms and improving general health and safety in a community requires work across multiple levels of the social ecology to: 1) develop transformative leadership to guide and facilitate community capacity building, 2) create communication strategies to identify norms and correct misperceptions of norms, 3) the development of an integrated portfolio of prevention strategies (e.g., policy, practice, system), and 4) time for critical reflection to learn from successes, challenges, and evaluation.

Positive Community Norms Framework
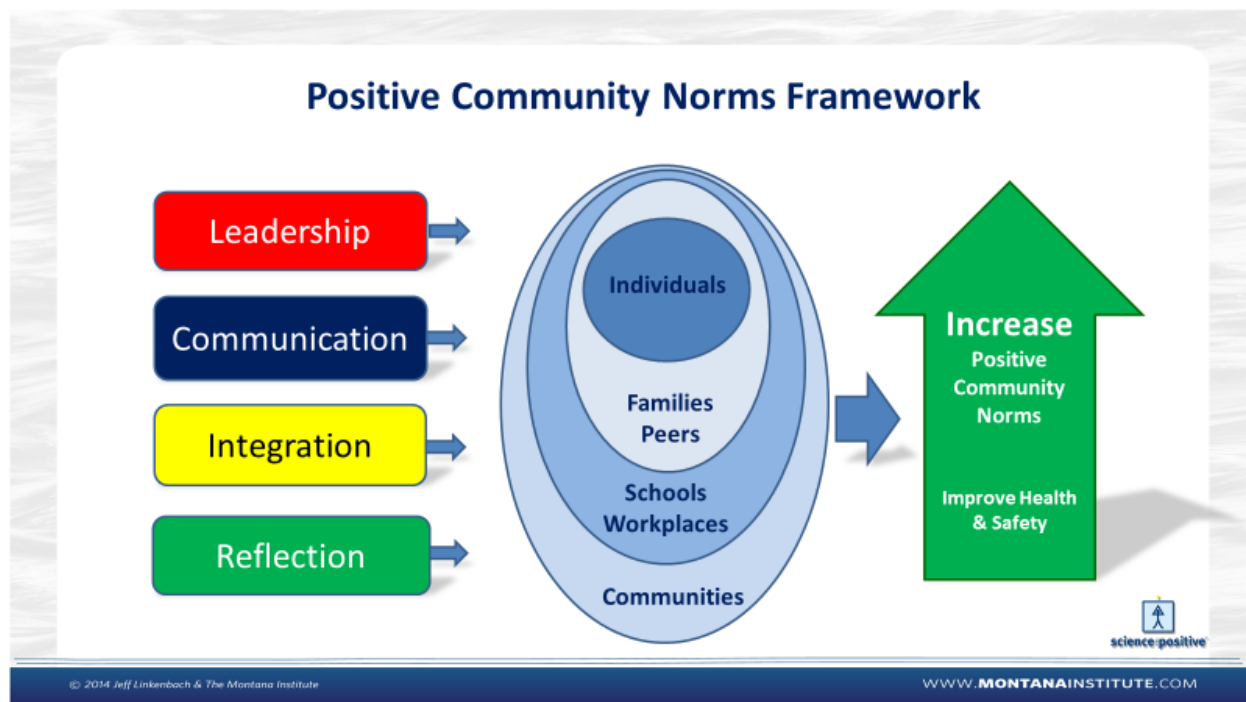
A number of states and communities have used the PCN framework and other normative approaches to guide transformation on issues related to sun protection (Mahler, Kulik, Butler, Gerrard, & Gibbons, 2008), drinking and driving (Perkins, Linkenbach, Lewis, & Neighbors, 2011), bullying (Perkins, Craig, & Perkins, 2011), and alcohol/tobacco use (Haines, Barker, & Rice, 2003) (see Linkenbach, 2017 for descriptions of these projects). Only recently has the PCN framework been applied to the issue of child maltreatment. Table 22 provides an example of two states (Wisconsin and West Virginia) who applied the Seven Step Montana Model of the PCN Communication to better understand and address issues related to child abuse and neglect.

Table 22. The Montana Model of PCN Communications.

Step in the Montana Model of PCN Communications	Wisconsin*	West Virginia**
1. Planning and environmental advocacy	Children's Trust Fund (CTF) of Wisconsin used a strategic planning process to determine the "essence" of their work	TEAM West Virginia worked on capacity building of key stakeholders and to define the vision and goals of their work
2. Baseline data	CTF developed a norms survey (Wisconsin Child Abuse and Neglect Prevention Survey) that assessed values, beliefs, and behaviors related to safe, stable, nurturing relationships and environments	TEAM West Virginia developed a survey to assess actual and perceived norms regarding safe, stable, nurturing relationships and environments as well as shaken baby syndrome (breastfeeding, safe sleep, and shaken baby syndrome).

Step in the Montana Model of PCN Communications	Wisconsin*	West Virginia**
		Administered survey to 663 parents of young children.
3. Message development 4. Communication plan	Using data from the baseline survey, values-based message was developed by leaders in Wisconsin in consultation with TMI and a public relations firm.	Findings from baseline survey indicated misperceptions regarding shaken baby syndrome and safe sleep. Materials were created by TEAM West Virginia (e.g., posters, brochures, video/audio pieces, toolkits) and distributed to providers, hospitals, and parents.
5. Pilot test and refinement	Message was piloted with early care and education professionals and members of the general public. As a result of feedback, minor changes were made to the message	Key stakeholders and parents provided feedback on messages. Slight changes were made to the messages prior to implementation.
6. Implement campaign	Creation of a website, social media, print/radio ads	Due to limited funding, materials were updated through existing communication channels
7. Evaluation	Ongoing	Seven key stakeholder interviews were conducted

*Source. Linkenbach, Klika, Jones, & Roche, 2017
**Source. Linkenbach, Klika, & McKay, in progress

Conclusions & Recommendations

The current evaluation was organized around the four areas of the CDC's Essentials for Childhood Framework. While a statewide list of primary and secondary prevention programs was not created, the evaluation was able to produce information on risk factors (by CFS region) for child maltreatment and information regarding the policy and practice landscape for children and families in Montana. Further, a review of social norms work was completed with examples of successful social norms campaigns in Wisconsin and West Virginia. Separate from this evaluation, a budget was submitted to the MT-CTF by Dr. Jeff Linkenbach, outlining proposed work related to social norms.

Below are the key recommendations from the evaluation.

Recommendation 1: *Participate in the maintenance of a statewide prevention resource list.* MT-CTF works with DOJ, OPI, and CFS to maintain a resource database and drive individuals and families to call 1-844-25CHILD (1-844-252-4453). The phone line and resource list is maintained by DOJ Child & Family Ombudsman, and all calls are answered or returned within

72 hours. It may be beneficial to assign AmeriCorps VISTAs in communities across the state to update the resources as a signature duty of their service term. While this resource list is cumbersome and continually evolving, it could allow MT-CTF to better understand the statewide prevention landscape and to strategically support primary and secondary prevention programs. Disseminating this list to child and family serving agencies in Montana may help facilitate cross-agency collaboration, especially in rural or resource-limited communities.

Recommendation 2: *Develop and conduct trainings on the public health approach to prevention.*
There was a great deal of confusion among practitioners and key stakeholders as to what activities and programs qualified as primary and secondary prevention. At times, respondents confused intervention (i.e., tertiary prevention) with primary prevention. Helping people better understand the goals and activities for primary and secondary prevention may help to create programs that address the risk factors for child maltreatment. Trainings would ensure that service providers are using a common language of prevention with a shared understanding of key prevention concepts.

Recommendation 3: *Address cultural needs in child abuse prevention programs.*
Although represented in all of the regions across Montana, findings of this evaluation indicate that Region 1 has the largest population of children under the age of 20 years who identify as Native American. It is imperative that any funded initiative for child maltreatment prevention in Montana, especially Region 1, should somehow explicitly address the cultural needs of the children and families being served. Working within indigenous communities, it is important for the MT-CTF to approach the work from a participatory-action framework, letting the communities and tribal elders lead the process. It may be helpful for the MT-CTF to develop an indigenous advisory council to consult on issues related to Native children and families. This advisory council may also help in conceptualizing, adapting, and implementing key prevention initiatives within indigenous communities.

Recommendation 4: *Support initiatives to address family economic indicators.*
Child maltreatment has been linked to various family economic indicators. In Montana, Region 6 demonstrated the highest need across all economic indicators (i.e., unemployment, poverty, average median income), highest rate of children receiving Healthy Montana Kids, and the highest participation in SNAP (Region 2 was close on most indicators). Improving family economic indicators holds promise in relieving the burdens that families face, making child maltreatment less likely.

Recommendation 5: *Monitor regional trends in child maltreatment.*
By tracking regional trends in child abuse and neglect over time, the MT-CTF will be positioned to address particular forms of maltreatment (i.e., physical abuse, neglect, sexual abuse, emotional abuse) in regions with the highest need. It will be important for the MT-CTF to work closely with CFS to obtain necessary data in the form most accessible for action planning. For example, it may be helpful to have child maltreatment data expressed as a percentage of the total child population instead of as raw counts of child maltreatment allegations. In this way, the MT-CTF can determine where need is greatest and can focus funding efforts towards those areas.

Recommendation 6: *Convene stakeholder group to finalize Zero to Three Toolkit and develop a plan of action.*

The purpose of the Zero to Three Toolkit is to provide key decision-makers with necessary data on statewide policies and practices that effect children and families, especially families with young children. The process by which the Toolkit is to be completed involves the collection of available data, key stakeholder review of the Toolkit, and planning for future action based upon the Toolkit results. In the current evaluation, the gathering of data occurred, yet no key stakeholder group reviewed the document for accuracy. Much of the data used to complete the Toolkit came from 2014-2015, and therefore may be out-of-date or inaccurate due to recent policy and/or practice changes. It is recommended that the MT-CTF convenes a key stakeholder group to review the results of the Toolkit, update any outdated or inaccurate information, and develop an action-plan based upon the results[5]. The key stakeholder group should consist of a diverse range of sectors (e.g., education, children's mental health, child welfare) with individuals who are aware of and have access to statewide data for their given sector. Once the Toolkit has been updated by the key stakeholder group, a policy and practice action plan should be developed to address the most pressing issues identified in the process. For example, in the current evaluation, it was identified that Montana does not provide paid family leave for families with new children. Research demonstrates that paid family leave has a positive influence on rates of hospitalizations for pediatric abusive head trauma (Klevens, Luo, Peterson, & Latzman, 2016). In the development of an action plan, the key stakeholder group may identify paid family leave as a policy priority for the state.

Recommendation 7: *Develop a plan for understanding and addressing social norms in Montana.*

The MT-CTF is encouraged to develop a plan for assessing social norms and creating messages and/or campaigns to align social norms with health-promoting behavior. To assess the effect of any social norms messages or campaigns, it is recommended that any plan of action would include assessment of social norms at multiple points in time to track shifts in social norms.

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[5] There are limitations to the types of advocacy activities that the MT-CTF can engage in. The key stakeholder group or another organization may need to take the lead in developing and implementing a policy and advocacy action plan.

References

Daro, D., & Gelles, R.J. (1992). Public attitudes and behaviors with respect to child abuse prevention. *Journal of Interpersonal Violence,* 7, 517-531.

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United and implications for prevention. *Child Abuse & Neglect*, *36*, 156–165.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*, 245–258.

Haines, M. P., Barker, G. P., & Rice, R. (2003). Using social norms to reduce alcohol and tobacco use in two Midwestern high schools. In H. W. Perkins (Ed). *The social norms approach to preventing school and college age substance abuse: A Handbook for educators, counselors, and clinicians*. San Francisco, CA: JosseyBass.

Herrenhohl, T.I., Hong, S., Klika, J.B., Herrenkohl, R.C., & Russo, M.J. (2013). Developmental impacts of child abuse and neglect related to adult mental health, substance use, and physical health. *Journal of Family Violence*, 28, 191-199.

Klevens, J., Luo, F., Peterson, C., & Latzman, N.E. (2016). Paid family leave's effect on hospital admissions for pediatric abusive head trauma. *Injury Prevention*, 22, 442-445.

Klika, J.B., Herrenkohl, T.I., & Lee, O. (2013). School factors as moderators of the relationship between physical child abuse and pathways of antisocial behavior. *Journal of Interpersonal Violence,* 28, 852-867.

Linkenbach, J. (2001). Cultural cataracts: Identifying and correcting misperceptions in the media. The Report on Social Norms: Working Paper No. (1). PaperClip Communications.

Linkenbach, J. (2016). *The Positive Community Norms process: A practitioner's workbook.* Bozeman, MT: The Montana Institute.

Linkenbach, J. (2016). *Applying the Science of the Positive to health and safety.* Available at http://www.montanainstitute.com/publications/

Linkenbach, J. (2017). An introduction to positive community norms. Available at http://www.montanainstitute.com/publications/

Linkenbach, J., Klika, J.B., Jones, J., & Roche, V. (2017). Preventing child maltreatment through the Positive Community Norms model. In R. Alexander (Ed.), *Prevention of Child Maltreatment*, St. Louis, MO: STM Learning, Inc.

Linkenbach, J., Klika, J.B., & McKay, J. (in progress). Exploring the Positive Community Norms framework for use with child maltreatment prevention.

Linkenbach, J., & Otto, J. (2014). *Promoting positive community norms*. Atlanta, GA: Centers for Disease Control and Prevention.

Mahler, H. I. M., Kulik, J. A., Butler, H. A., Gerrard, M., & Gibbons, F. X. (2008). Social norms information enhances the efficacy of an appearance-based sun protection intervention. *Social Science & Medicine*, 67, 321-329.

Perkins, H. W., Craig, D. W., & Perkins, J. M. (2011). Using social norms to reduce bullying: A research intervention among adolescents in five middle schools. *Group Processes & Intergroup Relations*, 1-20.

Perkins HW, Linkenbach JW, Lewis MA, & Neighbors C. (2010). Effectiveness of social norms media marketing in reducing drinking and driving: A statewide campaign. *Addictive Behaviors,* 35, 866–874.

U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth & Families, Children's Bureau. (2017). *Child Maltreatment 2015*. Available from https://www.acf.hhs.gov/cb/resource/child-maltreatment-2015